

# 2018 VFC Provider Enrollment

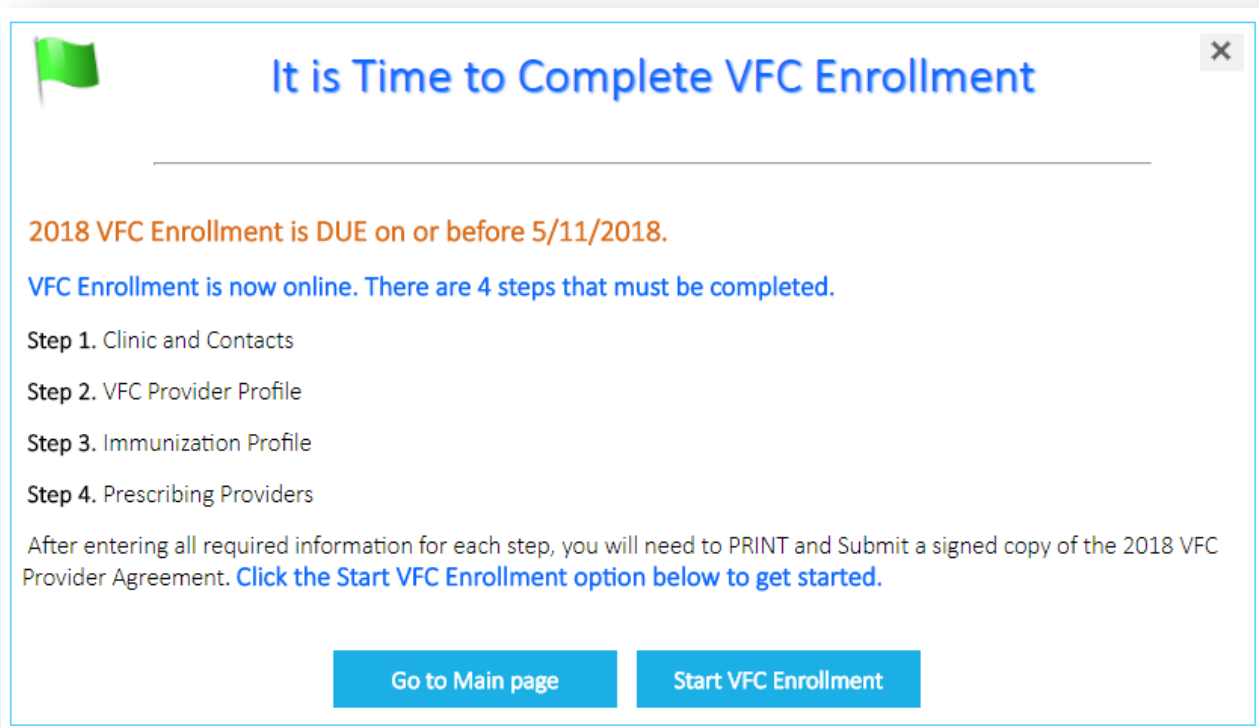
## Getting Started

Visit the web page [www.contactkswebiz.info](http://www.contactkswebiz.info) and login to your IV-4 account. If you do not have an IV-4 account, visit [www.contactkswebiz.info](http://www.contactkswebiz.info) and select the VFC tab and select *START HERE*. The system will first walk you through setting up your login and then send you through the VFC enrollment.



The screenshot shows the login page for the Kansas Immunization Program's IV-4 System. The header includes the "iV-4" logo and a navigation menu with links: Home, KSWebIZ Users, Healthcare Providers, Public Health, Pharmacies, EHR Vendors, IDNS Vendors, Help Desk, and VFC. The main content area features a large blue heading: "Welcome to the Kansas Immunization Program's IV-4 System!". To the right, there is a "Returning Users" section with a login form. The form includes fields for "Username:" and "Password:", followed by "Login" and "Clear" buttons. Below the form, there are links for "Forgot Password." and "Not Registered? Register Now."

Once you are logged in to your IV-4 account, you will see the VFC Enrollment reminder that indicates the due date and information needed to complete the enrollment. You may select *Go to Main page* or *Start VFC Enrollment*.



The screenshot shows a reminder window titled "It is Time to Complete VFC Enrollment". The window has a green flag icon in the top left and a close button (X) in the top right. The main text reads: "2018 VFC Enrollment is DUE on or before 5/11/2018." followed by "VFC Enrollment is now online. There are 4 steps that must be completed." Below this, a list of steps is provided: "Step 1. Clinic and Contacts", "Step 2. VFC Provider Profile", "Step 3. Immunization Profile", and "Step 4. Prescribing Providers". A paragraph follows: "After entering all required information for each step, you will need to PRINT and Submit a signed copy of the 2018 VFC Provider Agreement. Click the Start VFC Enrollment option below to get started." At the bottom, there are two blue buttons: "Go to Main page" and "Start VFC Enrollment".

If you select the option *Go to Main Page*, you can access the enrollment in your *Vaccines for Children* box by selecting *Click to Start VFC Enrollment*.



The system will guide you through several steps to collect information necessary to complete enrollment. You may logout at any time after completing a step. Be sure to complete the step you are on before logging out to save the information you entered. When you log back in, the system will prompt you to continue where you left off.

## What's New This Year

This year the Kansas Immunization Program will be collecting information on whether or not clinics maintain insurance coverage for loss of vaccine (e.g. in the event of a temperature excursion or power failure). Responses to this question will be required on condition #14 of the 2018 VFC Provider Agreement. You will be unable to submit the enrollment without providing a response to this question, so it is recommended that this information be collected before working on the Agreement.

## Information Collected During Enrollment

### Clinic's Physical Location

Facility Information (* required)			
*Facility Name	<input type="text"/>	VFC PIN #	<input type="text"/> <input type="checkbox"/> New Enrollment
*Facility Address	<input type="text"/>	Unit #	P.O. Box <input type="text"/>
*City	<input type="text"/>	*State	<input type="text"/> *Zip <input type="text"/>
*County	<input type="text"/>	*Country	<input type="text"/>
Telephone*	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Fax	<input type="text"/> <input type="text"/> <input type="text"/>

## Shipping Address

### Shipping Information

☐ Same as above

Shipping Address	<input type="text"/>	Unit #	<input type="text"/>	P.O. Box	<input type="text"/>
City	<input type="text"/>	State	<input type="text" value="Kansas"/>	Zip	<input type="text"/>
County	<input type="text"/>	Country	<input type="text" value="United States"/>		


## Medical Director

- Name (Last, First)
- Contact Information: Phone and email
- Declare if they have completed 2018 annual online VFC trainings provided by CDC
  - Vaccines for Children (VFC)-2018
  - Vaccine Storage and Handling-2018


*Please note: The CDC 2018 VFC Training Modules are not required for the Medical Director, they are optional. Selecting "no" when declaring completion of the modules is acceptable.*

### Medical Director or Equivalent

**Instructions:** The official VFC registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.

*Last Name	<input type="text"/>	*First Name	<input type="text"/>	MI	<input type="text"/>
*Title	<input type="text"/>	*Specialty	<input type="text"/>		
*License #	<input type="text"/>	Employer Identification Number (EIN)	<input type="text"/>		
*Email	<input type="text"/>				
 Please provide one or both of below requested identifiers. Either Medicaid or the prescribing provider's National Provider Identification (NPI) number MUST be entered.					
*Medicaid ID	<input type="text"/>	*Provider's NPI	<input type="text"/>		
*Has the Medical Director or Equivalent completed CDC's annual "You Call the Shots" training? <input type="radio"/> Yes <input type="radio"/> No					
If yes, please indicate, which trainings were completed?					
<input type="checkbox"/> Vaccines for Children (VFC) - 2018					
<input type="checkbox"/> Vaccine Storage and Handling - 2018					

#### Provide Information for second individual as needed:

Last Name	<input type="text"/>	First Name	<input type="text"/>	MI	<input type="text"/>
Title	<input type="text"/>	Specialty	<input type="text"/>		
License #	<input type="text"/>	Employer Identification Number (EIN)	<input type="text"/>		
 Please provide one or both of below requested identifiers. Either Medicaid or the prescribing provider's National Provider Identification (NPI) number MUST be entered.					
Medicaid ID	<input type="text"/>	Provider's NPI	<input type="text"/>		
*Email	<input type="text"/>				

## Primary Vaccine Coordinator

- A. Name (Last, First)
- B. Contact Information: Phone and email
- C. Declare if they have completed 2018 annual online VFC trainings provided by CDC
  - I. Vaccines for Children (VFC)-2018
  - II. Vaccine Storage and Handling-2018

## Backup Vaccine Coordinator

- A. Name (Last, First)
- B. Contact Information: Phone and email
- C. Declare if they have completed 2018 annual online VFC trainings provided by CDC
  - I. Vaccines for Children (VFC)-2018
  - II. Vaccine Storage and Handling-2018

### VFC Vaccine Coordinator

It is required for your designated Primary and Backup VFC Vaccine Coordinators to complete CDC's "You Call the Shots" online Training modules [Vaccines for Children \(VFC\) - 2018](#) & [Vaccine Storage and Handling - 2018](#). Training Certifications received for completing the training must be submitted to complete your application of enrollment in the VFC Program.

#### Primary Vaccine Coordinator

\*Last Name  \*First Name  MI   
\*Telephone    x  \*Email

\*Has the Primary Vaccine Coordinator completed CDC's annual "You Call the Shots" training? ☐ Yes ☐ No

If yes, please indicate, which trainings were completed?

- ☐ Vaccines for Children (VFC) - 2018
- ☐ Vaccine Storage and Handling - 2018

#### Backup Vaccine Coordinator

\*Last Name  \*First Name  MI   
\*Telephone    x  \*Email

\*Has the Backup Vaccine Coordinator completed CDC's annual "You Call the Shots" training? ☐ Yes ☐ No

If yes, please indicate, which trainings were completed?

- ☐ Vaccines for Children (VFC) - 2018
- ☐ Vaccine Storage and Handling - 2018

## Facility Information

### Facility Information

Select ☐ Public ☒ Private

Does this facility ONLY provide vaccines to adults? ☐ Yes ☒ No

Facility Type

## Approved Vaccine Delivery Times

### Approved Vaccine Delivery Times

Day	From Time 1	Through Time 1	From Time 2	Through Time 2
Monday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tuesday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Wednesday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Thursday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Friday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Saturday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sunday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## Vaccine Profile – Population Served by Your Clinic

Any provider that is currently Direct Entry KSWebIZ and in 2017 input data for a minimum of 3 months can access instructions for the Eligibility Category Patient Count Report by selecting [here](#).

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
No Health Insurance	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
American Indian/Alaska Native	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Underinsured in FQHC/RHC or deputized facility <sup>1</sup>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Total VFC:</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Non-VFC Vaccine Eligibility Categories	# of children who received non-VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Insured (private pay/health insurance covers vaccines)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Children's Health Insurance Program (CHIP) <sup>2</sup>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Total Non-VFC:</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Total Patients</b> (must equal sum of Total VFC + Total Non-VFC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="button" value="Calculate Totals"/>				
<p><sup>1</sup>Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.</p> <p>In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate these underinsured children.</p> <p><sup>2</sup>CHIP – Children enrolled in the state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.</p>				

## Type of Data Used to Determine Provider Population

### TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION (choose all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Benchmarking           | <input type="checkbox"/> Doses Administered      |
| <input type="checkbox"/> Medicaid Claims Data   | <input type="checkbox"/> Provider Encounter Data |
| <input type="checkbox"/> IIS                    | <input type="checkbox"/> Billing System          |
| <input type="checkbox"/> Other (must describe): |  |

Provide the following information for all prescribing providers in the clinic:

### Enter Provider Information (\* required)

All licensed health Care providers (MD, DO, NP and PA) at your facility who have prescribing authority must be identified.

#### \* Required Provider Identifying information:


- |                        |                      |   |
|------------------------|----------------------|---|
| 1. First Name          | 4. Title             | 7. Medicaid Number                        |
| 2. Last Name           | 5. Specialty         | 8. National Provider Identificaiton (NPI) |
| 3. Middle Initial (MI) | 6. Medical License # | 9. Employer Identification Number (EIN)   |

\*How many providers are there in this location?


### Enter Provider Information (\* required)

\*Do you have an Individual NPI for this Provider? ☐ Yes ☐ No

Adding 1 of 1

*Last Name	<input type="text"/>	*First Name	<input type="text"/>	MI	<input type="text"/>
*Title	<input type="text"/>	*Specialty	<input type="text"/>		
*License No	<input type="text"/>	Employer Identification Number (EIN)	<input type="text"/>		
 Please provide one or both of below requested identifiers. Either Medicaid or the prescribing provider's National Provider Identification (NPI) number MUST be entered.					
*Medicaid ID	<input type="text"/>	*Provider's NPI	<input type="text"/>		

The system will automatically validate NPI numbers and provider data. If invalid NPI numbers or provider data is entered, the system will return a warning.



 **NPI Registry Alert!**  
Provider data not found in NPI Registry.

To reconcile invalid NIP numbers and/or provider data, select *Edit* next to the provider's name.

Current Provider List


Add Provider


Cancel

#	Review	Last Name	First Name	MI	Title	Specialty	License #	Medicaid #	NPI #	EIN	Edit	Remove
1		Cain	Kathy		MD	Pediatrics	0426358	100414540A	1669498663		Edit	

You will need to correct what the system has identified as incorrect.

**Edit Provider Information** (\* required)

*Last Name	<input type="text" value="Cain"/>	*First Name	<input type="text" value="Kathy"/>	MI	<input type="text"/>
*Title	<input type="text" value="MD"/>	*Specialty	<input type="text" value="Pediatrics"/>		
*License No	<input type="text" value="0426358"/>	Employer Identification Number (EIN)	<input type="text"/>		
 Please provide one or both of below requested identifiers. Either Medicaid or the prescribing provider's National Provider Identification (NPI) number MUST be entered.					
*Medicaid ID	<input type="text" value="100414540A"/>	*Provider's NPI	<input type="text" value="1669498663"/>		

 **NPI Registry Alert!**  
1. First Name found on NPI Registry is different: **Kathleen**

## Enrollment Submission Method

To sign the 2018 VFC Provider Agreement using the electronic signature feature, select *Sign & Submit VFC Agreement*.

VFC Agreement Submitted					Sign & Submit VFC Agreement
#	Date Submitted	Approved	Date Approved	View Form	
No Records Found.					

Prior to signing the 2018 VFC Provider Agreement, the system will require you to review the information entered and conditions of the enrollment.

Condition 14 will require you to identify if your facility has insurance to cover the loss of vaccine. You will not be allowed to proceed with signing the 2018 VFC Provider Agreement if condition 14 is not answered.

I agree to replace vaccine purchased with state and federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.	
14.	<p>a. Does your facility have insurance to cover this loss of vaccine? <input type="radio"/> Yes <input type="radio"/> No</p> <p>b. The facility understands that, with or without insurance to cover vaccine, they have full financial responsibility for the replacement of non-viable vaccine due to provider negligence.</p>

After the 2018 VFC Provider Agreement has been completely reviewed, you will need to check the box indicating that you agree to the terms and conditions as set forth by the Kansas Immunization Program.

KANSAS IMMUNIZATION PROGRAM 2018	
By signing this form, I certify on behalf of myself (Medical Director or authorized to sign for Medical Director) and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Facility Name: Test Provider Site	VFC PIN #:
Signature <input type="checkbox"/> I agree to the above terms and conditions as set forth by the Kansas Immunization Program.	Date: 04/09/2018
Signed electronically by:	

Checking the box will generate a pop-up window that requires you to select *I Accept*.

KANSAS IMMUNIZATION PROGRAM 2018	
By signing this form, I certify on behalf of myself (Medical Director or authorized to sign for Medical Director) and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Facility Name: Test Provider Site	VFC PIN #:
Signature <input checked="" type="checkbox"/> I agree to the above terms and conditions as set forth by the Kansas Immunization Program.	Date: 04/09/2018
Signed electronically by:	

Electronic Signature Agreement - Google Chrome

74.118.245.168/kswebizcmsUAT/iacceptvfc.asp

**Electronic Signature Agreement**

By selecting the "I Accept" button you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your mutual signature on this Agreement.



The system will populate your name in the *Signed Electronically By* box. You can select *Print All* if you wish to print the agreement. You must select the *Submit* box below the signature line to finalize the submission of the enrollment.

KANSAS IMMUNIZATION PROGRAM 2018	
By signing this form, I certify on behalf of myself (Medical Director or authorized to sign for Medical Director) and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Facility Name: Test Provider Site	VFC PIN #:
Signature <input checked="" type="checkbox"/> I agree to the above terms and conditions as set forth by the Kansas Immunization Program.	Date: 04/09/2018
Signed electronically by: Darrin TestEnroll	

BackSUBMITPrint All

The system will provide you confirmation that the 2018 VFC Provider Agreement has been submitted successfully.

Provider VFC Agreement was submitted successfully!
<button>CLOSE</button>

## What to Expect After Submitting

You will be notified by email when your enrollment has been approved or if changes need to be made.

All **new** Primary and/or Backup VFC Vaccine Coordinators will need to register for access to KSWebIZ, as each VFC Vaccine Coordinator is required to have training and access to KSWebIZ to submit monthly VFC reports and orders.

**New** Primary and/or Backup VFC Vaccine Coordinators can proceed with registering for KSWebIZ by visiting <https://kanphix.kdhe.state.ks.us/> and selecting the link labeled *WebIZ*.

If you would like to view your agreement, you can select *View Agreement* from the *Main* page at any time.

## Enrollment Questions

Questions about your 2018 VFC Enrollment should be directed to your VFC Regional Consultant. To determine who your consultant is, you can visit the following web page:

[http://www.kdheks.gov/immunize/vfc\\_program.html](http://www.kdheks.gov/immunize/vfc_program.html)

You may also submit a Support Ticket in IV-4 by selecting the *Help Desk* tab.

